I would like to recognize the Orange County School of Culinary Arts as a benchmark for other programs to follow. This program will not only alleviate the shortage of professionally-trained chefs, it will open a world of opportunities to neighboring citizens. From now on, a student can now pay for a professional training equal to those of the finest academies for a fraction of the cost. The Orange County School of Culinary Arts stands before us as a shining example of success for other communities to follow in the coming years.

A CENTURY OF EXCELLENCE—THE YORK COUNTY CHAMBER OF COMMERCE TURNS 100

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. GOODLING. Mr. Speaker, January 13, 1997 marked the 100th anniversary of one of south central Pennsylvania's most important and prolific organizations. Originally established in 1898 as the York Merchant's Association, the York County Chamber of Commerce has continued to faithfully carry out its mission to expand economic opportunities for commercial, mercantile, and industrial companies while enhancing accessibility to area products.

York County has benefitted immeasurably from the existence and activity of the Chamber. Ranging from the $1.5 million raised by the Chamber in 1925 to connect the neighboring communities in Lancaster County via the Wrightsville Bridge, to the development of a communications link between Chamber members and worldwide customers via the Internet, the Chamber has always been working to bring people together in the best interest of our community. They have succeeded over and over again in making York a better place to live.

But York is not the only beneficiary of the Chamber's efforts. During its early years, the York County Chamber of Commerce helped lead the national effort to recognize and promote business interests by becoming the eighth charter member of the nearly formed Chamber of Commerce of the United States in 1908. This grassroots leadership has not only helped to propel the U.S. Chamber of Commerce to the prominent place it holds today as one of the top voices for the business industry, but also to place the York Chamber among the top 10 percent of chambers nationwide.

Despite a few changes in name and location, the York County Chamber of Commerce has remained the guiding force for local businesses for 100 years. That is why we should take the time to recognize this important milestone in the history of York County and its business community. Without their efforts, York County would not have achieved the level of prosperity we enjoy today. I am pleased to associate myself with this important organization and join them as they celebrate their centennial.

IMPROVING MEDICARE QUALITY-SAVING MEDICARE LIVES: SUPPORT FOR H.R. 2726

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. STARK. Mr. Speaker, the AARP Public Policy Institute issued a paper in December of 1996 by Dr. David Nash, entitled ''Reforming Medicare: Strategies for Higher Quality, Lower Cost Care.'' It is a excellent paper on a number of ways to improve and extend the life of Medicare.

One proposal in Dr. Nash's paper is the ''centers of excellence'' concept, in which Medicare can contract with certain hospitals to provide a high volume of complicated procedures in exchange for a lower global payment. The results of Medicare's ''demonstrations'' of this concept shows that Medicare can save money while increasing quality for beneficiaries.

Following is Dr. Nash's discussions of the Heart Bypass Center Demonstration. The Administration had proposed legislation in the FY 97 Budget Reconciliation bill to implement this type of proposal nationwide. The House passed the proposal, but it was dropped in Conference. I hope that Congress will revisit this issue in 1998 and enact this concept.

It is not just a matter of dollar—it is a matter of lives.

Medicare, like most private insurance, has historically paid hospitals and doctors separately. Since 1983 with the introduction of the Prospective Payment System (PPS), Medicare has paid hospitals a fixed price for most care based on the patient's diagnosis. Doctors, whose medical decisions still affect nearly 80 percent of hospital costs, continue to be reimburse on a fee-for-service basis that rewards them for doing more, not less.

The Medicare participating Heart Bypass Center Demonstration project is an experimental project implemented by Medicare in early 1992. Two primary events drove the planning for this important demonstration project: namely, the results of numerous studies showing a strong correlation between relatively higher volume, lower cost, and better outcomes in open heart surgery services, and unsolicited proposals from individual hospitals willing to provide coronary artery bypass graft (CABG) services for a fixed price.

This demonstration project was implemented to answer four basic questions: 1) Is it possible to establish a managed care system with Medicare Part A and Part B payments combined, including all pass throughs for capital, medical education, etc., and pay a single fee to the hospital for treating patients? 2) Would it be possible to decrease the Medicare program's expenditures on CABG surgery while maintaining or improving quality? 3) What is the true relationship between volume and quality in CABG surgery, and can hospital procedure volume be increased without decreasing the level of appropriateness? and 4) What is involved at a hospital operational level—can such a program be sustained over a period of time without draining financial resources and dragging the organization down?

Preliminary results evaluating the Medicare participating Heart Bypass Center Demonstration project, I believe, strongly support its immediate national expansion to appropriately realign the incentives between hospitals and their physicians. By creating a strong financial incentive to be more cost effective in their use of resources, hospitals and doctors will be able to implement the tools of continuous quality improvement, practice guidelines, critical pathways, and the nonpunitive feedback of information about performance. In a word, they will utilize many of the tools mentioned throughout the body of this report to improve quality and lower costs.

For example, the seven experimental heart surgery site institutions have reported numerous operational changes resulting in lower costs and improved quality as a result of the HCFA demonstration project. Quick transfers out of intensive care, shorter patient stays after surgery, fewer laboratory and radiology tests, and the use of care management and critical pathways, are some of the cost cutting measures being employed at each of the participating institutions. Expensive consultations with other physicians were also targets for cost saving. Participating institutions report a nearly 20 percent decrease in the use of consultation with no demonstrable changes in overall case outcomes. At four demonstration sites, doctors and administrators together are challenging long-standing patterns of care and scrutinizing the use of everything from $5 sutures to intensive care unit beds at $800 per day. At St. Joseph's Hospital, in Atlanta, Georgia, neurologists were charging between $364 and $1,676 for a neurologic consultation before the program began; now the hospital pays them a flat rate of $371. In the post-operative period, physicians are removing particular chest drainage tubes in certain patients within 24 hours rather than waiting the customary 48 hours, a strategy that even may foster quicker healing. Physicians describe the demonstration project as making them rethink each step along the patient care continuum. If each step is not supportable on a scientific basis, and is not in the patient's best interest, it is removed, and, as a result, costs are reduced.

Of course, many managed care organizations and some specialty practices have often charged a global fee for procedures or for a specified time period of care such as one calendar year. A growing number of managed care companies have negotiated special package price deals for expensive or high-tech procedures including organ transplantation, maternity care, and cancer care. The Medicare program should proceed quickly with preliminary plans to expand the participating Heart Bypass Center Demonstration project and begin a 'National Centers of Excellence'' program on other high-cost, high-volume procedures. The literature is clear that practice makes perfect and an expansion of this program, which would realign incentives, reduce costs, and inevitably improve quality, ought to be implemented quickly.

Finally, consideration should be given to expanding the current prospective payment system to include outpatient care. Studies ought to be undertaken to link inpatient and outpatient claims for particular procedures and particular diagnoses such as congestive heart failure, pneumonia, diabetes and other high-cost, chronic illnesses. With the availability of improved outpatient case mix systems, HCFA has an opportunity to provide national leadership and use its evaluative capacity to realign incentives between doctors and hospitals.